PPS-Exempt Cancer Hospitals Quality Reporting Program Quality Reporting (PCHQR) Program

Support Contractor

FY 2017 IPPS/LTCH Final Rule – Focus on the PCHQR Program

Presentation Transcript

Moderator/Speaker:

Lisa Vinson, BS, BSN, RN
Project Manager, PPS-Exempt Cancer Hospitals Quality Reporting (PCHQR) Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

Speakers:

Caitlin Cromer, MA
Program Lead, PCHQR Program
Social Science Research Analyst, Quality Measures and Value Incentives Group (QMVIG)
Center for Clinical Standards and Quality, CMS

Tom Ross, MS
Program Lead, PCHQR Program
Hospital Inpatient VIQR Outreach and Education SC

August 25, 2016
2 p.m. ET

Lisa Vinson: Good afternoon. We would like to welcome everyone to today's webinar entitled *Fiscal Year 2017 IPPS/LTCH Final Rule* with a Focus on the PCHQR Program. Our presenters today will be Caitlin Cromer, Program Lead, PPS-Exempt Cancer Hospital Quality Reporting Program, Social Science Research Analyst, Quality Measures and Value Incentives, Center for Clinical Standards and Quality, CMS; Tom Ross, PPS-Exempt Cancer Hospital Quality Reporting Program Lead, Hospital Inpatient Values, Incentives and Quality Reporting Outreach and Education Support Contractor; and myself, Lisa Vinson, Project Manager for the Hospital Inpatient VIQR Outreach and Education Support Contractor. Today's webinar is part of the series for the PPS-Exempt Cancer Hospitals, or

Support Contractor

PCHs, participating in the PPS-Exempt Cancer Hospital Quality Reporting Program. As the title indicates, today we will be discussing the Fiscal Year 2017 IPPS/LTCH Final Rule. This Final Rule has sections that address the Hospital Inpatient Quality Reporting program and the Long-Term Care Hospital Quality Reporting Program, in addition to the PPS-Exempt Cancer Hospital Quality Reporting Program. Please note that during this webinar, we will only be discussing the PCHQR Program section of the proposed rule. If your facility is participating in the HIQR or LTCH Program, please contact your support contractor to find out when there will be a presentation regarding your section of the 2017 Final Rule. If you have questions about the content of today's presentation, please submit them using the chat function. As time allows, our presenters will address these during today's event. If time does not allow all questions to be answered during today's event, remember that the slides, recording, transcript, and questions and answers will be posted following today's event on Quality Reporting Center and *QualityNet*. And now, let us look at the next slide.

As usual, here is the Acronyms and Abbreviations slide. Please use this slide for reference as we go through the webinar. Acronyms and abbreviations you will hear and see today include FY for fiscal year, IPPS for Inpatient Prospective Payment System, LTCH for Long-Term Care Hospital, CLABSI for Central Line-Associated Bloodstream Infection, CAUTI for Catheter-Associated Urinary Tract Infections and EBRT for External Beam Radiotherapy. As always, feel free to print this slide out and post at your desk or somewhere else for easy reference.

Slide seven provides the purpose of today's webinar. As the slide states, the purpose of today's presentation will provide a review of the fiscal year 2017 IPPS/LTCH Final Rule, focusing on how these changes impact the PCHQR, as well as summarizing the CMS responses to comments

received during the rulemaking process. Now, on slide eight, let us look at the objectives for today's webinar.

As slide eight indicates, there are three objectives for today's webinar: locate the fiscal year 2017 IPPS/LTCH Final Rule text, identify PCHQR changes within the fiscal year 2017 Final Rule, and summarize the CMS responses to comments received during the rulemaking process. On slide nine, we will look at some more information about the Final Rule.

Slide nine outlines the date of the publication of the fiscal year 2017 Final Rule. Also, there is a link to the fiscal year 2017 Final Rule. As indicated on slide eight, a display copy of the Final Rule was published on August 2, 2016. We have provided a link to this document. The content specific to the PCHQR program is found on pages 1757 through 1798 of this document. The official Federal Register version is scheduled to be published on August 22, 2016. Due to the timing of today's event, we were not able to provide this link in this slide deck. In the very near future, a link to the Federal Register PDF version of the rule will be posted on QualityReportingCenter.com as well as on *QualityNet*. A Listserv will also be sent to those subscribing to the PPS-Exempt Cancer Hospital notifications when the Federal Register version is available online. And now, on slide 10…

… I will turn the presentation over to the CMS program lead for the PPS-Exempt Cancer Hospital Quality Reporting program, Caitlin Cromer. Caitlin?

Caitlin Cromer: Thank you, Lisa. During the May PCHQR Outreach and Education event, we reviewed the fiscal year 2017 IPPS/LTCH proposed rule. During this, we went into a lot detail about the rationale for proposed changes. For today's event, we will be reviewing these again but at a higher level focusing more on the public comments that we were – that were received and the CMS responses to these comments. We at CMS value and listen

carefully to all comments made and thank you for your input. It not only helps to develop the Final Rule but also helps to provide direction as we work on future processes and measures to be utilized in the PPS-Exempt Cancer Hospital Quality Reporting Program. In response to previous questions and input from the PCHs and other stakeholders, we developed a section of the Final Rule addressing the criteria for removal and retention of PCHQR Program measures. We will begin our review of this section on slide 11.

Previous rules have received public comments requesting information as to the criteria for removing measures from the program. To align this rationale with those used in other programs, these criteria are based upon the criteria used in the Hospital Inpatient Quality Reporting, or IQR, Program. There are seven criteria that we will use in evaluating PCHQR program measures when considering their removal from this program. These are listed on this slide, and you can see that they include: high and unvarying performance among the PCHs on the measure; changes in the literature that may make the current measure obsolete; emerging evidence that the measure does not improve quality or that a better measure has become available; or that the measure is not feasible to implement due to system or data burden considerations. Despite the existence of these criteria, there are times when measures may meet some of the criteria for removal but continue to bring value to the program. These circumstances are listed on our next slide, slide 12.

Once again, these criteria align with those that were published in the 2016 Final Rule for the Hospital IQR program. The reasons to retain a measure, even when it meets some of the criteria for removal, include alignment with other CMS and Health and Human Services, or HHS, policy goals or alignment with other CMS programs. Once again, to reduce data burden, support the effort to move PCHs towards reporting electronic measures.

Support Contractor

We received a couple of comments on these criteria, which we will discuss on the next slide, slide 13.

The first comment supported the proposed criteria for the removal and retention of measures and recommended flexibility in determining whether measures are topped out, expressing concern that the proposed criteria could lack validity when applied to a small cohort of PCHs. We thank the commenter for their support. Although there are only 11 PCHs, we believe that they are all achieving performance within the top quartile, that is, it is reasonable to review the measure to determine whether it has been topped out. A second commenter recommended that if these criteria are adopted, the three cancer-specific treatment measures be removed as being topped out. We thank the commenter for this recommendation and will consider this in the future. After consideration of the comments received, we are finalizing the measure removal and retention policy as proposed. On slide 14, we will take a look at the next section of the Final Rule…

… which addresses the retention and update to previously finalized quality measures for PCHs beginning with the fiscal year 2019 program year. The fiscal year 2017 Final Rule is the fifth rule issued for the PCHQR Program. On this slide is a summary of the four previously issued rules with hyperlinks to the PDF versions of each rule from the Federal Register. As the PCH participants are aware, Section 3005 of the Affordable Care Act established the quality reporting program for hospitals designated as PPS-exempt cancer hospitals and that for fiscal year 2014 and each subsequent fiscal year, a PCH must submit data to the secretary. These are rules that establish the current 16 quality measures for the PCHQR Program that the PCHs must submit data for. This is down from 22 measures with the final submission of the six SCIP measures in the data submission period that ended on August 15, 2016. One commenter supported the continued inclusion of NQF number 0431,

the CDC NHSN Influenza Coverage Among Health Care Personnel, or HCP, measure. We thank the commenter for their support.

On slide 15, we will review our proposed retention of these measures as well as an update to one of them. There is no proposal to remove any of the previously finalized measures from program year 2018. However, there was a proposal to update one measure, NQF number 382, Oncology Radiation Dose Limit to Normal Tissues. This proposal was to expand the diagnoses cohort on the current population of patients receiving 3D conformal radiation therapy for lung or pancreatic cancer to also include the diagnosis or breast or rectal cancer. As this is to be effective for the 2019 program and subsequent years, this would be for patients receiving 3D conformal radiation therapy for these diagnoses starting on January 1, 2017. The support contractor will soon have the modified measure information forms, or MIFs, and algorithms available. And will also update the PCHQR Program Manual to reflect these changes. The rationale for this extension of the diagnoses cohort is on the next slide, slide 16.

As previously discussed in the proposed rule webinar, this expanded diagnoses cohort has been endorsed by the NQF and we strive, when possible, to have alignment with existing NQF-endorsed specifications. The rationale is the high prevalence of these cancer types. Due to these high incidences, we believe that the expansion of this measure cohort will help to ensure high-quality care being delivered in the PCHs. As required by legislation, this recommendation was placed on the list of Measures Under Consideration, or MUC list, for December 1, 2015, and the Measures Application Partnership, or MAP, endorsed this measure in its 2016 recommendations. On slide 17, we will review the comments and responses…

… to the addition of breast and rectal cancers to this quality measure. Two commenters supported the expansion of the diagnoses cohort to include breast and rectal cancer. One commenter that supported the expansion urged delay until the expansion received NQF endorsement. We thank the commenters for their support. The NQF endorsed the measure with the expanded cohort in 2014. We are aligning our measure with the updated NQF-endorsed specifications. Of note, the 2015 MAP conditional support was based only on – was based only on NQF's regular annual update, out of which we expect to arise no significant concerns. NQF review is still underway for the annual updates to this measure. The expanded cohort, however, was endorsed by NQF in 2014. Our proposal would expand the cohort pursuant to NQF's 2014 endorsement of the cohort expansion and is not impacted by the regular annual review process in which NQF engages on all measures. We consider the MAP's recommendations and the importance of aligning with the NQF-endorsed specification of measures whenever possible when we proposed the update to the PCHQR program. After consideration of the public comments we received, we are finalizing the update to measure specifications as proposed. We have proposed one new measure for inclusion beginning with the fiscal year 2019 program year. And on the next slide, slide 18…

… reviews and considerations we used in the selection of quality measures. Previous IPPS/LTCH Final Rules have outlined the principles CMS takes into consideration when developing and selecting measures for the PCHQR Program. These principles are modelled after those we use for measure development in the Hospital IQR Program. Section 1866(k)(3)(A) of the act requires that the PCHQR measures be endorsed by an entity with a contract under Section 1890(a) of the act. This endorsement is currently performed by the National Quality Forum, or NQF. The second bullet on the slide explains that Section 1866(k)(3)(B) provides an exception that the secretary may specify a measure not so endorsed as long as due consideration is given to existing endorsed or

adopted measures. Using these principles for measure selection in the PCHQR Program, we are proposing one new measure for inclusion in the PCHQR Program. We will begin examining the fifth proposed new metric on the next slide, slide 19.

As we did a detailed review of proposed new measures entitled Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy in May, we will just do a high-level recap of this measure. This measure is for the fiscal year 2019 program and subsequent years. The data for fiscal year 2019 would be obtained from outpatient chemotherapy administered between the dates of July 1, 2016, through June 30, 2017; and then, use data from July 1 through June 30 for each subsequent year. This is an outcome measure with the overall goal of reducing the number of Emergency Department, or ED, visits and hospital admissions following the patient receiving outpatient chemotherapy at a PPS-exempt cancer hospital. Again, this is a patient receiving chemotherapy in an outpatient setting. The aim of this measure is to assess the care provided to cancer patients and encourage quality improvement efforts that will ultimately decrease admissions and ED visits. Several commenters generally opposed the adoption of the proposed new measure because the MAP conditionally supported it pending NQF endorsement and the NQF has not formally announced its decision. We thank the commenters for their views regarding the MAP review and NQF endorsement. In evaluating and selecting the measure for inclusion in the PCHQR program, we considered whether there were other available measures that have been endorsed or adopted by the NQF and we were unable to identify any other NQF-endorsed measures that assess admissions and ED visits following outpatient chemotherapy. We developed the measure using the same rigorous process that we used to develop other publicly reported outcomes measures. As part of that process, we sought and received extensive input on the measure from stakeholders and clinical experts. We believe that adoption of this

measure will result in an improved quality of life and decrease overall expenditures, as outlined on slide 20.

In terms of quality of life, it is anticipated that this measure will foster physical and emotional well-being, ease disruption of patient schedules, allow more engagement in work and social activities, and decrease the burden placed on the family and caregivers of those patients receiving outpatient chemotherapy. The second set of bulleted items illustrates the fact that the use of outpatient chemotherapy is very prevalent and its use is increasing. Furthermore, there are significant fiscal implications, noting that Medicare payments for cancer care was almost 10 percent of the Medicare fee-for-service in 2010, or $34.4 billion, and that the average cost for chemotherapy-related admissions is $22,000, and the average chemotherapy-related emergency room visit costs $800.

To try to decrease these adverse outcomes, the measure addressed the preventable chemotherapy-associated adverse events displayed on the slide. These 10 qualifying diagnoses are anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, and sepsis. A link to the methodology details is provided in the Final Rule. Several commenters opposed the adoption of the proposed new measure as currently specified because of concerns that the diagnoses and symptoms that are subject to the measure, such as pneumonia, could be due to causes other than chemotherapy side effects and are not appropriate to combine. One commenter also stated that the list of ICD-10 codes contained in this measure submission documents includes codes for diagnoses that are unrelated to chemotherapy and further suggested that the measure does not differentiate between chemotherapy-related and unrelated admissions and emergency department visits. Given the increase in outpatient hospital-based chemotherapy, understanding and minimizing related unplanned admissions and ED visits is a very high priority. The 10 conditions that the measure captures are commonly-cited reasons for hospital visits

among patients receiving chemotherapy in the hospital outpatient setting and are potentially preventable through appropriately managed outpatient care and increased communication with patients. This measure will help identify unplanned admissions and ED visits in patients receiving outpatient chemotherapy by reviewing claims in which these 10 conditions considered potentially preventable through appropriately managed care and are listed as a primary diagnosis or secondary diagnosis accompanied by a primary diagnosis of cancer. Admissions and emergency department visits for those conditions is a potential sign of poor-quality care and poor care coordination. While the goal is not to reach zero admissions and ED visits, the premise is that reporting this information will promote and improve patient care over time for two reasons. First, transparency and publicly reporting this measure will raise the hospital and patient awareness of unplanned hospital visits following chemotherapy. Second, this reporting will incentivize hospital outpatient departments to incorporate quality-improvement activities into their chemotherapy care planning in order to improve care coordination and reduce the number of these visits. We also believe that making PCHs aware of this performance, as well as the performance that might be expected given the PCHs' case mix, is helpful in supporting efforts to improve outcomes. The measure is intended to improve symptom management and care coordination for patients who are undergoing chemotherapy. Many professional societies and others have published evidence- or consensus-based guidelines to mitigate the occurrence of these adverse events. Many of these organizations are listed on the next slide, slide 22.

Guideline from the American Society of Clinical Oncology, National Comprehensive Cancer Network, Oncology Nursing Society, Infectious Diseases Society of America, and other professional societies recommend evidence-based interventions to prevent and treat common side effects and complications of chemotherapy. Appropriate outpatient care should

reduce potentially-avoidable hospital admissions and ED visits for those issues and improve cancer patients' quality of life.

As was noted in the previous webinar, this new measure aligns with two of the current PCHQR process measures; NQF 0384, Pain Intensity Quantified, and NQF 0383, Plan of Care for Pain. However, the proposed measure improves on these two measures in two key ways. First of all, it does not target a specific symptom but, rather, assesses the overall management of 10 important symptoms. Secondly, it assesses the outcomes that matter to patients rather than measuring processes to detect and treat these conditions. One commenter recommended that if we did adopt this measure for the PCHQR, we retire two currently active measures, NQF 0383, Plan of Care for Pain, and NQF 0384, Pain Intensity Quantified. We thank the commenter for the recommendation and will consider it in the future. The process measures, which are not risk-adjusted, support the purpose of the proposed measure by reinforcing that those providing outpatient care should screen for and manage symptoms, such as pain and anemia or fatigue. We believe that having these process measures, which are directly within the control of the PCH, complements the newly-adopted outcome measure. However, we do recognize that having all three measure in the program may place undue burden on facilities. We will continue to assess the appropriateness of including all three measures after we have more data on the correlation between PCH performance in all three measures.

Slide 24 begins a review of the basics of the measure. I would like to summarize a few points from this slide. This is claims-based measure. The information is obtained from Medicare fee-for-service Part A and Part B administrative claims data. There will be no additional data submission by the PCHs. This measure is risk-adjusted. One of the qualifying diagnoses on the admission or ED visit claim must be in the primary diagnosis or a secondary diagnosis accompanied by a primary diagnosis of

cancer. Furthermore, the admission or ED visit must be within 30 days after the PCH outpatient chemotherapy treatment encounter. Lastly, the outcomes for inpatient admission and emergency department visit are identified separately. Slide 25 discusses the exclusion criteria.

First of all, please note that the measure does not include patients receiving oral chemotherapy only. There are three specific exclusions for this measure. The first is a diagnosis of leukemia at any time during the measurement period. The second is those patients who are not enrolled in the Medicare fee-for-service Parts A and B in the year prior to the first outpatient chemotherapy encounter. And, the third exclusions is those patients who do [not] have at least one outpatient chemotherapy treatment encounter followed by 30 days of continuous enrollment in Medicare fee-for-service Parts A and B after the encounter. A number of commenters recommended that there be additional or broader denominator exclusions from the measure. Specifically, commenters urged that patients with hematologic malignancies beyond leukemia, such as lymphoma and multiple myeloma, be excluded from the measure, as patients with leukemia are currently excluded. Commenters also recommended exclusions for a wide variety of other factors, including but not limited to patients enrolled in clinical trials and patients receiving palliative care. We thank the commenters for their suggestions on additional denominator exclusions. We specified the measure to be as inclusive as possible. We excluded based on clinical rationale only those patient groups for which hospital visits were not typically a quality signal or for which risk adjustment would not be adequate. Based on feedback from early public comments suggesting that the exclusion of all patients with a hematologic malignancy would be too broad and our analyses showing that patients with lymphoma and multiple myeloma have similar rates of admission and ED visits when compared with patients with other cancer types, we decided during development to limit the exclusion criteria to only those patients with leukemia. As part of continued evaluation, we will consider

reviewing rates stratified by cancer type to track the impact and inform future measure revisions. We do not exclude patients enrolled in clinical trials because there are many challenges associated with systematically identifying these patients and collecting information on applicable clinical trials. We cannot identify these patients using claims data, and many cancer patients participate in clinical trials. We do not exclude patients receiving palliative care because published literature shows that all patients receiving outpatient chemotherapy, regardless of their reason for chemotherapy, be it palliative or curative, may experience a gap in care that leads to acute potentially-preventable hospitalizations. Improving patients' quality of life by keeping patients out of hospitals is the main goal of quality cancer care, especially at the end of life. On slide 26, we will look at the risk adjustment for this proposed measure.

There are two risk adjustment models: one for the inpatient admissions, for which where were 20 relevant variables identified, and one for the emergency department visit, for which there were 15 variables identified. Commenters identified concerns regarding the risk adjustment methodology, including the measure's use of administrative data not capturing certain information for risk adjustment or stratification, such as cancer staging, chemotherapy toxicity levels, or patient generic information. We cannot identify cancer staging, chemotherapy toxicity levels, or patient genetic information using claims data. However, we believe that the risk adjustment methodology as specified is valid. The measure is risk-adjusted to help account for the variation in patient mix and aggressiveness of treatment, adjusting for demographic factors, such as age and sex, comorbidities, cancer type and the number of treatments during the measurement period. For example, aggressiveness can range by cancer type and age, which are accounted for in our model. Also, we adjust the number of treatments, which may also be an indicator of treatment aggressiveness. This risk adjustment modelling is applied to

raw data to provide a more accurate reflection of performance in the analysis of the PCH outcomes, which is expressed as outlined on slide 27.

The numerator, the predicted number of outcomes, is the risk-adjusted actual patients with the measured adverse outcome and admission or ED visit. The denominator is the number of patients with the measured adverse outcomes the PCH is expected to have based on the national performance with that particular PCH's case mix. If the predicted is greater than the expected, the ratio will be greater than one and the risk standardization rate will be higher than the national observed rate. If the predicted is less than the expected, the ratio will be less than one and the risk standardized rate will be lower than the national observed rate. The national observed rate is that obtained from combining the data from all the PCHs over the measurement period. Each PCH will have two rates reported, a risk-standardized admission rate, or RSAR, and a risk-standardized ED visit rate, or RSEDR. Some commenters opposed the adoption of the measure because of general concerns with its validity and reliability, providing examples of ICD-10 codes not related to chemotherapy or inpatient admission in which a patient receives treatment for pain and nausea but in which the pain and nausea was not related to chemotherapy treatment. One commenter supported the measure provided it had been tested for validity and reliability. We disagree with commenters regarding the proposed measure's reliability and believe that this measure is sufficiently reliable to be included in the PCHQR Program. The Final Rule contains the details of further statistical analysis that has been done to assess the validity and reliability of this measure. Slide 28 explains how these rates will be reported.

Each PCH who has 25 or more eligible patients per measurement period will have both the RSAR and the RSEDR publicly reported. To prepare the PCHs for this public reporting, we are planning to conduct a dry run or confidential national reporting of the measure's results prior to public

reporting. The purposes of this dry run are to educate PCHs and other stakeholders, to allow PCHs to review their results prior to public reporting, answer questions about the measure, to test the production and reporting process, and to identify technical changes that may be needed. There will be more information about the dry run in the future. Additionally, we will be devoting the November 17 PCHQR Outreach and Education event to a detailed review of this measure. There were numerous comments received in regards to this proposed new measure.

We have addressed many of them as we have reviewed the content of the new measure Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy. For a detailed review of all comments received and our responses, participants are directed to the 2017 IPPS/LTCH Final Rule. CMS thanks all commenters for their input and recommendations. These will all be kept in consideration as we work with this measure in the future. After consideration of the public comments received, we are finalizing the adoption of this new measure for the PCHQR program as proposed. On the next three slides, starting with slide 30, we will review the previously-finalized and newly-finalized PCHQR measures for the fiscal year 2019 program year and subsequent years.

First, we see the six metrics in Safety and Health Care-Associated Infection domain: CLABSI, CAUTI, SSI for colon and abdominal hysterectomy surgeries, CDI, MRSA, and the influenza vaccination for health care personnel. The first submission of the *Clostridium difficile* and MRSA measures occurred just recently in August. Also, remember that this upcoming influenza season, October 1, 2016, through March 31, 2017, will be the first time that PCHs submit data on the HCP measure. This submission will occur in the data submission period closing on May 15 of 2017 and will be transmitted by NHSN on your behalf based upon the data you have entered in the system.

Support Contractor

This slide, slide 31, is a continuation of the previous slide. Here, we see the three cancer-specific treatment measures and the five oncology care measures, which have previously been added to the PCHQR Program. Note that for NQF 382, we are proposing an expansion, as previously discussed, of the diagnosis cohort to include breast and rectal cancer. This will be effective for patients being treated starting on January 1, 2017, and will be reported in August 2018 and applied to the fiscal year 2019. Also, please note that for NQF 0559, the staging has been updated to include patients with AJCC T1c N0 M0 or Stage IB-III hormone receptive – hormone receptor-negative breast cancer. This does not reflect the change in the measure inclusion criteria, but rather is reflective of an update in the AJCC staging and the associated NQF update.

We propose to continue to include both HCAHPS and EBRT in the PCHQR program. And here, we see the addition of the proposed new measure Admission and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy.

On slide 33, we will look at the comments received per our request on feedback for measure topics that we should consider for future rulemaking. We received two comments about possible new quality measures for future years. One commenter thanked CMS for its thoughtful approach to measure development. The commenter urged CMS to incorporate additional outcome measures into the PCHQR Program, such as patient-reported outcome measures, condition-specific outcome sets, and an unplanned readmissions measure. One commenter urged CMS to include stakeholders throughout the measurement development process. We at CMS thank the commenters for their input and look forward to continuing our collaborative efforts through mechanisms currently in place, such as technical expert panels, or TEPs, as well as an – as well as notice and comment periods during rulemaking.

On slide 34, we will review what the Final Rule contains related to public reporting.

To make data publicly available as soon as possible, we proposed to not specify exact timeframes during rulemaking. Rather, as implementation allows, we want to continue to communicate the exact dates via website and/or ListServe. We propose that the timeframe for PCHs to review their data prior to it publicly – being publicly available would be approximately 30 days. As no comments were received, we are finalizing these proposals. We also propose to add NQF 1822 or EBRT to be publicly reported during calendar 2017, displaying the data that was collected on patients treated during the calendar year 2015. You recently reported this data. One supportive comment was received and we are finalizing the proposal. On our next slide, slide 35…

… we will look at changes to NQF 382 as well as the recommendation to defer the public reporting of CLABSI and CAUTI data. As discussed previously, since the proposal to expand the diagnoses cohort for NQF 0382 is now finalized, we will denote this on *Hospital Compare* so that consumers and others are aware of this change. There was a request for clarifying the data collection dates and for the cohort expansion. The expanded diagnosis cohort would be collecting calendar year 2017 and reported in August 2018 with public reporting in December of 2018. We had proposed to delay the public reporting of CLABSI and CAUTI. These were slated to be publicly reported in 2017 and subsequent years. However, due to the low volume of data produced and reported by the small number of facilities, we require additional time to work with the CDC to identify an appropriate timeframe for public reporting and collaborate on the analytic methods that will be used to summarize this data for public reporting purposes. Two respondents supported our recommendation to defer public reporting of these measures pending further collaboration with the CDC. We have finalized this decision to

defer the public reporting of CLABSI and CAUTI. The changes to public reporting are summarized on the table on our next slide, slide 36.

We will continue to publicly report the two chemo and one hormone cancer-specific treatment measures that are currently publicly reported. The OCM and HCAHPS measures will be added for the PCHs in December 2016 to *Hospital Compare*. There will be a webinar for the PCHs in October to review this in more detail. The diagnosis cohorts for Radiation Dose Limits to Normal Tissues or NQF 0382 will be expanded to include breast and rectal cancers in addition to the current lung and pancreatic cancers for patients treated in the calendar year 2017. CLABSI and CAUTI, which were slated for reporting starting in 2017, are now deferred until a later date. And lastly, NQF 1822 or EBRT is proposed to be publicly reported starting in 2017. There are a few components of the PCHQR Program that remain unchanged, and these are listed on our next slide, slide 37.

The background statutory support and participation requirements remain unchanged. The data submission requirements and deadlines remain unchanged for the previously-finalized measures and are available on *QualityNet*. Also, the current extraordinary circumstances process remains the same. We truly thank you for your input, value your comments and look forward to continuing to collaborate with the PPS-Exempt Cancer Hospitals and other – and other stakeholders as the program continues to evolve. And now, I will turn the presentation back over to Tom for the remainder of this event. Thank you. Tom?

Tom Ross: Thank you, Caitlin. On this slide, we see the upcoming webinars for the remainder of 2016. Please note that the September 22 event, which had been planned for Analysis of LabID events has been changed to be the PCHQR Program: Lessons Learned in Population and Sampling and also lessons learned from EBRT. We had a lot of good learning experiences

during the recent data submission that we want to share with you. The Analysis and LabID event will be done in the future once the system changes with NHSN are completed. The October event, which Caitlin referred to in her comment, is focused on public reporting for the PCHQR program. This event has moved up earlier in the month than usual so that you can be educated on the public reporting of the Oncology Care Measures and HCAHPS, which will start in the December refresh of *Hospital Compare*. This webinar will be during your public reporting preview period, so I think it should be very helpful. The new PCHQR measure finalized in the fiscal year 2017 IPPS/LTCH Final Rule, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy will be the topic for the November event. And lastly, we will close the year with a review of 2016 and look ahead to 2017. Related to this, keep your eye on *QualityNet* and Quality Reporting Center in the upcoming month as many of the tools related to the changes in the program due to the Final Rule will be posted. Most significant will be the use of new diagnosis codes and the diagnosis cohorts for NQF 382. Now I know you just ended a major data submission period for this year. However, recall that the DACA is due by August 31. This is available on *QualityNet* and Quality Reporting Center. You can email this in or fax. The directions are on the form itself. And, lastly, working with your vendor, be aware that the next submission of the HCAHPS data, that's for quarter two 2016, will be on October 5, 2016. I also want to share with the attendees a happy yet sad, for me, announcement. Henrietta Hight, who many of you worked with over the past two years, is officially retiring after 20 years of service with our organization. She is such a wealth of information and such a great co-worker. She will be greatly missed. We certainly wish Henrietta all the very best as she stays busy in her retirement. And, with that, I will turn the presentation over to Deb Price to discuss our continuing education process. And then, we will have the closing comments from Caitlin. Deb?

Support Contractor

Deb Price: Well, thank you very much. Today's webinar has been approved for one Continuing Education credit by the boards listed on this slide. We are now a nationally-accredited nursing provider and, as such, all nurses report their own credits to their boards using the national provider number 16578. It is your responsibility to submit this number to your own accrediting body for your credits.

We now have an online CE certificate process. You can receive your CE certificate two ways. The first way is, if you register for the webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk®, please pass the survey to them. After completion of the survey, you will notice at the bottom right-hand corner a little gray box that says "Done." You will click the Done box, and then, another page opens up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk®. Please use your personal email for this separate registration, so you can receive your certificate. Health care facilities have firewalls that seem to be blocking our certificates from entering your computer.

If you did not immediately receive a response to the email that you signed up with the Learning Management Center, that means you have a firewall up that is blocking the link into your computer. Please go back to the New User link and register a personal email account. Personal emails do not have firewalls up. If you can't get back to your New User link, just wait 48 hours because, remember, you are going to be getting another link in another survey sent to you within 48 hours.

OK. This is what the – what the survey will look like. It will pop up at the end of the event and will be sent to all attendees within 48 hours. Click Done at the bottom of the page when you are finished.

This is what pops up after you click Done on the survey. If you have already attended our webinars and received CEs, click Existing User. However, if this is your first webinar for credit, click New User.

This is what the New User screen looks like. Please register a personal email like Yahoo! or Gmail or ATT since these accounts are typically not blocked by hospitals firewalls. Remember your password, however, since you will be using it for all of our events. You will notice you have a first name, a last name, and the personal email. And, we are asking for a phone number in case we have some kind of back-side issues that we need to get in contact with you.

This is the what the Existing User slide looks like. Use your complete email address as your user ID and, of course, the password you registered with. Again, the user ID is the complete email address including what is after the @ sign.

OK. Now, I am going to pass the ball back to your team lead to end the webinar and to go over any questions that came in. Thank you for taking the time spent with me.

Caitlin Cromer: This is Caitlin at CMS. And, I would just like to thank everybody for spending time listening to us, and have a great rest of your day.

END